STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING **NVS3190HOS** 08/05/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10301 JEFFREYS ST **HEALTHSOUTH REHABILITIATION HOSPITAL** HENDERSON, NV 89052 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) S 000 Initial Comments S 000 This Statement of Deficiencies was generated as a result of a State Licensure focused re survey and complaint investigation conducted in your facility on 8/5/10 and finalized on 8/5/10, in accordance with Nevada Administrative Code, Chapter 449, Hospital. Complaint #NV00025900 was substantiated with deficiencies cited. (See Tag S298) A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included. Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations. actions or other claims for relief that may be available to any party under applicable federal, state or local laws. S 089 NAC 449.316 Emergency Preparedness S 089 SS=E 2. A hospital shall develop and carry out a comprehensive plan for emergency preparedness which: (a) Addresses internal and external emergencies. both local and widespread; and (b) Is based on current standards for disaster management and fire safety. This Regulation is not met as evidenced by:

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

Based on document review, the facility failed to

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING_ **NVS3190HOS** 08/05/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10301 JEFFREYS ST **HEALTHSOUTH REHABILITIATION HOSPITAL** HENDERSON, NV 89052 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 089 Continued From page 1 S 089 conduct fire drills on a quarterly basis for each shift. Findings include: 1. There were no documented fire drills conducted from 2/10 to present. Severity: 2 Scope: 2 S 175 NAC 449.338 Dietary Services S 175 SS=C 6. In providing for the preparation and serving of food, a hospital shall: (a) Comply with the standards prescribed in chapter 446 of NRS and the regulations adopted pursuant thereto This ELEMENT is not met as evidenced by: Based on observation, interview, and record review on 8/5/10, the facility failed to ensure the kitchen complied with the standards of NAC 446. Findings Include: 1. Cleaning and Sanitation Issues: a. There was excess metal shavings observed on the table under the kitchen can opener. b. The outside garbage containers were found uncovered. c. There were multiple floor sinks throughout the kitchen, dishroom, and hospital nourishment rooms that were excessively soiled and/or obstructed with debris.

2. Equipment and Maintenance Issues:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

NVS3190HOS

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

08/05/2010

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HEALTHSOUTH REHABILITIATION HOSPITAL

10301 JEFFREYS ST HENDERSON, NV 89052

| HEALTHSOUTH REHABILITIATION HOSPITAL HENDERSON, NV 89052 | | | | | | | | |
|--|---|---------------------|--|--------------------------|--|--|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE | | | | |
| S 175 | Continued From page 2 | S 175 | | | | | | |
| | a. The walk-in freezer condenser fans had excess ice build-up.b. There were household refrigerators and household microwaves located within each nourishment room of the hospital. | | | | | | | |
| | Severity: 1 Scope: 3 | | | % | | | | |
| S 219 SS=E | NAC 449.340 Pharmaceutical Services | S 219 | | | | | | |
| | 5. Drugs and biologicals must be controlled and distributed in a manner which is consistent with applicable state and federal laws. This Regulation is not met as evidenced by: Based on observation, interview and record review the facility failed to insure expired medication was not stored at the facility. | | | | | | | |
| | Findings include: | | | | | | | |
| | On 8/5/10 the following expired medications were found inside the medication room; | | | | | | | |
| | 1. 2 Insulin pens with expiration dates 09 and 4/10. | | | | | | | |
| | 2. 1 Insulin vial past 30 day open date | | | | | | | |
| | 3. 6 bags of D5.45 NS with 10 meq of K expired 8/4/9. | | | | | | | |
| | 4. 2 expired culture bottles. | | | | | | | |
| | 5. Seven vials of antibiotics with various expired dates. | | | | | | | |
| | | | | | | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|--|------------------------------|--|--|--|--|--|
| NVS3190HOS | | | | B. WING | | 08/05/2010 | | |
| NAME OF PROVIDER OR SUPPLIER STREET | | | | DDRESS, CITY, STATE, ZIP CODE | | | | |
| DEXITOENITO DEGROUITIATINA UNCOITAL | | | FFREYS ST SON, NV 89052 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | TION SHOULD BE CONTROL | | |
| S 219 | Continued From page 3 | | | S 219 | | | | |
| | On 8/5/10 five expired Heparin locks (expiration dates (4/08 and 10/08), and one vial of Lidocaine (expiration date 2/09) were found in the crash cart. | | | | | | | |
| | The facility's medical storage policy dated 8/01 and revised 5/10 indicated that "pharmacy stock shall be examined at least quarterly for drugs expiring during the next 12 months, and colored dots placed on the storage bins according to the expiration log schedule for the corresponding quarter. Any drugs expiring during the current quarter will be removed from stock and segregated for disposition. Stock in the Pyxis will be examined, removed if expiring, and replaced if appropriate." | | | The state of the s | | | | |
| S 298 SS=E | proper treatment ar nursing services in | ing Service ensure that its patien nd care provided by i accordance with nat ds of practice and ph | its ionally | S 298 | | | | |
| | Based on record re interview the facility received proper tre it's nursing services | not met as evidence view, document reviy failed to ensure paratment and care prosin accordance with for 2 of 4 patients (parate) | ew and tients vided by | | | | | |
| | Findings include: | | | | | | | |
| | #1 indicated the lef | rders dated 5/10/10 to theel was to have S ith CaAlg dressing. | antyl with | | | | | |

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PRINTED: 08/06/2010 FORM APPROVED

Bureau of Health Care Quality and Compliance STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING **NVS3190HOS** 08/05/2010 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 10301 JEFFREYS ST **HEALTHSOUTH REHABILITIATION HOSPITAL** HENDERSON, NV 89052 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) S 298 Continued From page 4 S 298 medication administration record lacked documentation of the left heel being medicated and the dressing changed with Santyl, Polysporen and CaAlg on 5/12/10, 5/13/10 or 5/14/10. 2. Patient #3's nurses notes contained inconsistent wound documentation. Scope 2 Severity 2 Complaint # NV00025900

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